PART IV.

MEDICAL MISCELLANY.

Reports, Transactions, and Scientific Intelligence.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

President—LOMBE ATTHILL, M.D., F.R.C.P.I.
General Secretary—JOHN B. STORY, M.B., F.R.C.S.I.

SECTION OF PATHOLOGY.

President—E. J. McWEENEY, M.D.
Sectional Secretary—A. H. WHITE, F.R.C.S.I.

Friday, December 5, 1902.

THE PRESIDENT in the Chair.

Sarcoma of the Left Suprarenal Capsule.

DR. EARL showed a case of this disease with secondary growth in the thorax, involving the right lung, the pericardium, and right auricle, and causing narrowing and thrombosis of the superior vena cava.

THE PRESIDENT wished to know whether the material found inside the superior vena cava was in the nature of a thrombus, and if so whether Dr. Earl regarded it as an embolus or as something which grew from the lung and auricle into and through the walls of the vein—*i.e.*, whether it was a thrombus due to loss of vitality or to growth of the tumour? He said it would be interesting to study the relations of the tumour to the walls of the vein and of the auricle, as to whether it infiltrated these structures or not.

DR. EARL, in replying, said that he looked upon the material as an ordinary thrombus, due to slowing of the circulation and infiltration of the vein walls. He made no microscopic examination of it, but it was partly white, partly red, and probably did not contain any tumour tissue.

Cancer of the Transverse Colon.

DRS. MAUNSELL and EARL showed this case. There was a small polypus in the neighbourhood of the tumour, which presented histological characters which appeared to indicate malignancy.

PROFESSOR O'SULLIVAN said he was inclined to regard the polypus as an adenomatous growth due to irritation of the malignant growth. He had seen a case in which there was a row of these lying round the cancer.

THE PRESIDENT said it would be interesting to find two malignant tumours existing independently of each other, for example in the bowel. If he had seen the specimen without previous knowledge of it he would have thought it more than a simple tumour. He thought it was a cancer of the bowel in its very initial stage.

DR. EARL, in replying, agreed that if it was malignant it was a very early stage. Dr. O'Sullivan had mentioned a case in which there was a ring of these growths round a cancer, and said that he considered them innocent, but he might as well have considered them malignant if they had a structure similar to that which he now showed. He said that two independent malignant processes did sometimes occur—there might be a cancerous tumour on one wall of the œsophagus, and another on the other wall, with healthy tissue between. The question of the changes of cells was of most importance in connection with curettings of the uterus. Though the structure of the mucous membrane of the intestine was not the same as that of the uterus, the same general laws held good.

Dropsy of the Gall-Bladder.

DR. EARL showed a case due to obstruction of the cystic duct by a gall-stone.

Intraocular Tumour.

MR. ARTHUR BENSON read the notes of a case which occurred in the left eye of a child, aged three. Six months before admission to St. Mark's Ophthalmic Hospital, the creamy white reflex from the pupil was noticed, but there was no pain apparently. On admission the cornea and lens were perfectly clear, the iris was discoloured and vascular, with numerous vessels visible on its surface. The vitreous chamber was completely filled by a creamy coloured tumour, which had moulded itself against the posterior surface of the lens. The tension of the eye was · + 2 ; this, added

to the appearances, made the diagnosis of pseudo-glioma very improbable, whilst the age of the child was against sarcoma of the choroid, so that glioma of the retina was the most probable diagnosis. Enucleation was done and the globe examined by Dr. Neville, who reported as follows :—" On microscopical examination the tumour shows the characters of a round-celled sarcoma, of a markedly cylindromatous type. The tumour cells form well-marked sheaths for many of the vessels, in the neighbourhood of which the cells are both larger and stain better than they do outside the range of immediate nutritive supply. There are areas of hæmorrhage, and also semi-necrosis, where nuclei stain feebly, and scattered through the mass are many areas of calcification, some smaller vessels having completely calcareous coats. Examined unstained the cells do not show any abnormal pigmentation. Mallory's glia-stain fails to show any gliomatous structure, and the sections so far made do not help to solve the question of the origin of the tumour. The remaining part of the tumour is being decalcified."

THE PRESIDENT fully agreed in not giving the name glioma to the tumour. In most of these cases of intraocular tumour springing from the retina, the characteristic spider cells were not seen, even in staining by the Golgi method. True glioma of the retina was very rare. He had heard of a case of a child, aged four, who was attacked by this disease in both eyes, and from each of them there was a tumour projecting as large as a closed fist of an adult.

DR. EARL could not agree with Drs. McWeeney and Neville in calling these growths sarcomata. They could be traced to the retina itself, and our ordinary view of sarcomata was that they were connective tissue growths, while there was very little of this tissue in the retina. Again, in ordinary glioma of the brain the spider cells were not found with any readiness, and the growths there also frequently resembled sarcomata. He considered neuro-epithelioma the best term for such tumours as Mr. Benson showed.

PROFESSOR O'SULLIVAN said that the tumour seemed to consist of two parts, one surrounding the vessels and consisting of large cells, and the other consisting of small round cells corresponding in appearance to those found in what is called glioma of the retina. He did not see why these tumours should be called gliomata, considering they were derived from the inner molecular layer of the retina. The different characters of the two parts of this tumour seemed to him to make the diagnosis unusually complicated and difficult.

THE PRESIDENT said there were certainly two kinds of cells of different sizes in the tumour, one with large nuclei packed close together and little protoplasm, the other with very small nuclei and no protoplasm. The nomenclature of these tumours was very unsatisfactory. There were two standpoints from which to consider them, the morphological and the histogenetic. Morphologically these tumours were to be classed with small, round-celled sarcomata. Histogenetically they might belong to the epithelial class of tumours. Whether they originated from epiblastic sources was open to discussion. Supposing those cells were of epithelial origin, morphologically they did not resemble epitheliomata ; they were sarcomata.

The Section then adjourned

SECTION OF SURGERY.

President—L. H. ORMSBY, P.R.C.S.I.

Sectional Secretary—JOHN LENTAIGNE, F.R.C.S.I.

Friday, December 12, 1902.

THE PRESIDENT in the Chair.

Cystic Tumour of the Brain.

MR. E. H. TAYLOR read a paper on cystic tumour of the brain. The patient, a man, aged thirty-two, had enjoyed good health up to March, 1901. Subsequent to this date he began to experience progressive weakness in his left lower extremity, which extended upwards so as to involve his arm and his face, also on the left side to some extent. Sensation was somewhat dulled on the paralysed side. There had never been any convulsive attack or giddiness. The classical symptoms of intracranial pressure were very marked—viz., optic neuritis with progressively failing sight, frequent and paroxysmal headache and vomiting. The diagnosis made was that of a subcortical tumour in the right cerebral hemisphere and in the vicinity of the motor area. Operation was performed on April 26th, 1902. A large omega-shaped flap, 3 ins. by 3 ins., was raised, including the scalp and the subjacent bone ; two-thirds of the flap lay in front, one-third behind, the line indicating the fissure of Rolando, or the sulcus centralis. In the process of elevating the bone a number of small trephine holes were made and the intervening bridges of bone divided with Gigli's saws. The dura when exposed was very tense and did not pulsate. On dividing the membrane and turning it aside, the brain bulged into the opening in an alarming fashion. No tumour

was visible or could be felt; fluctuation, however, was very evident quite close to the brain surface. An incision made through the cortex permitted the escape of a quantity of clear, straw-coloured fluid, the result being that the brain instantly collapsed and receded very considerably from the inner aspect of the cranium. A sterilised soft rubber tube, introduced into the cavity for drainage purposes, could be pushed easily in different directions, revealing a cavity of some magnitude. The bone flap and dura mater were replaced, and the tube brought out through one of the trephine holes at the posterior margin of the flap. Meningeal hæmorrhage caused some trouble and delayed the concluding steps of the operation. Patient bore the operation well. There was temporary paralysis in the left arm for some time afterwards; however, the after-course of events has been satisfactory; the left lower extremity has recovered its power, so also has the upper extremity. The patient is able to perform his regular work as well as usual, and has never had any symptoms of headache or vomiting since the operation. His sight has also improved. An interesting feature of the case is that more than three months ago a slight convulsive seizure occurred in the left arm, suggestive of the onset of Jacksonian epilepsy; for this the patient was put on fairly large doses of bromide of potassium. His general health is excellent at present, and according to his own statement he has never been better; his vision too, has improved. The last observation as to the patient's condition was made on November 28th, seven months after the operation.

MR. MAUNSELL said that he thought that the fracturing of the base of the bone flap was not right. It would be better if it were first nearly sawn through with a Gigli saw.

SIR THOMAS MYLES in a case of glioma had found the introduction of the Gigli saw very difficult; it had, however, the merit of causing little or no bleeding. Sir Thomas explained why Mr. Maunsell's method was not applicable. He thought it was impossible to make a differential diagnosis between a cystic tumour and a glioma.

DR. HAUGHTON said that if the centre of motor disturbance was located it might have been better to make a small trephine hole over the tumour, introduce a small needle and ascertain if it were a fluid tumour. This method would not cause much brain disturbance and would give the necessary information.

THE PRESIDENT detailed a case of abscess of the brain he had recently operated on with good results.

MR. E. H. TAYLOR said his own experience was that the bone breaks cleanly across. If a spicule did appear it could easily be snipped off with a forceps. The difficulties in brain tumours were three in number. 1. Diagnosis. 2. In what part is a tumour situated? 3. Is it capable of being removed? With regard to the trephine holes, he said if he were doing the operation again he would just make two and make vertical sections on each side with the forceps. With regard to anatomical measurements he said he thought it desirable to define approximately the underlying portions of the cortex. He found a depressed fracture situated near the motor area. He did not approve Dr. Haughton's plan of trephining a small hole and putting in a small syringe.

Two Unusual Cases of Nephrectomy.

MR. R. C. B. MAUNSELL read a paper on two unusual cases of nephrectomy. The first case was that of a female infant of sixteen months, from whom he removed a congenital cystic kidney which weighed 3 lbs. 2 ozs. and measured 22 by 16 ins. in circumference. The child made an uneventful recovery. Mr. Maunsell advocated ether as the anæsthetic for children, and gave his reasons for choosing an oblique incision commencing at the eighteenth intercostal space and sloping to the middle line below the umbilicus, the sheath of the rectus being opened without cutting the muscle fibres. The second case was one of pyonephrosis, complicated by subphrenic abscess following occlusion of the ureter. Mr. Maunsell treated it by Ollier's subcapsular nephrectomy, and gave reasons for this choice. The pathology of the cystic kidney was then discussed and it seemed to support the theory of an origin in fœtal papillitis.

MR. TAYLOR thought the subcapsular method of securing the kidney very useful in some cases.

MR. LENTAIGNE said that he had found the subcapsular method of operation very easy in a case of tuberculous kidney without perinephritis. He related a case in which he had drained both kidneys for calculous pyelitis with complete success.

MR. GORDON said that in these congenital cystic kidneys the affection was bilateral, and one would fear that the second kidney might become inefficient. He considered the incision from tip of the last rib towards the sheath of the rectus a very good one.

DR. WAYLAND said that as regarded anæsthetics for children he agreed with Mr. Maunsell that ether is better than chloroform.

There were only two drawbacks to ether: 1.—It was more unpleasant; 2, there was a liability to accumulation of mucus. Both these were only temporary, and the second one ceased soon after commencement of operation.

MR. MAUNSELL, in replying, said that the reason he performed nephrectomy in this case was that he knew the history of the case, and that there was no chance of the ureter becoming pervious. Besides, the patient was moribund from cancer. He thought the subcapsular should be the primary operation in such a case, as the pedicle could be got at in case of hæmorrhage. He said he always gave ether to children, even in removing tonsils and adenoids.

The Section then adjourned.

SECTION OF MEDICINE.

President—A. V. MACAN, M.B., P.R.C.P.I.

Sectional Secretary—R. TRAVERS SMITH, M.D.

Friday, December 19, 1902.

DR. WALTER G. SMITH in the Chair.

The Finsen Treatment for Lupus.

DR. C. M. O'BRIEN read a paper based on his experiences of a year's trial of this method. He exhibited a number of patients already subjected to the method, and gave short, descriptive histories. The cases presented great variety in extent, character, and duration, which varied from two to twenty-eight years. The cure of some and improvement of all attended his efforts, while the cure of others appeared to him to be merely a matter of time. As regards permanency of cure he was of the opinion that the method was entitled to a premier place in this respect. This opinion he formed from personal examination of many cases at the Finsen Institute, Copenhagen, that were cured, and remained so from one to six years. He gave a demonstration of the lamp and its method of application, and said that most of the objections hitherto complained of in the use of the French lamp as compared with the Finsen lamp could be obviated by prolonging the duration of each sitting, while at the same time increasing the intensity of the light. The reactions were in all cases better, and penetration to the deeper tissues more manifest.

THE CHAIRMAN said that, as regarded test of cure, naked eye

inspection was not sufficient. His method was to press blood away from the part with a watch glass, and see whether any of certain characteristic brown nodules were still left in the skin. There were different methods of treatment: 1. Excision. He thought that this, combined with careful suturing, gave good results in suitable cases. 2. Caustic treatment, which he did not consider a good one. 3. Radiant energy treatment, of which the Finsen light was a form. The Finsen rays might be defined as filtered light, as only the violet end of the spectrum is used. The action of the light was conditioned by the body on which it fell. In the therapeutic contrast between Finsen rays and X-rays, the latter appeared to have a much more stimulant effect on nutrition of skin than the Finsen rays. The X-rays will promote growth of hair, but if pushed too far will produce a depilatory effect.

SIR GEORGE DUFFEY said that in the Royal City of Dublin Hospital they had used the Finsen light since April last, and had had a number of cases which were more or less successful. As regarded cosmetic effect it seemed to be extremely useful in some cases; in other cases the disease was entirely arrested. He had used certain applications in conjunction with the light treatment when the disease was spread over too large a surface for the lamp to cover at once, such as a weak ointment made with pyrogallic acid. He had sittings of fifteen minutes, and even this he sometimes found too long. Some cases reacted more than others. The scar left was more pliable and softer than that resulting from any other treatment.

DR. WATSON said he had treated about twenty cases of skin disease with X-rays. He used the ordinary apparatus, covering up all the sound tissues with lead foil. It was mostly used in those cases of lupus which had refused operation, but those cases which had been previously scraped reacted quicker and better.

DR. KIRKPATRICK had seen a good many cases of lupus treated by scraping, and he thought the reason that this treatment had fallen into disrepute was that patients expected to be cured by one operation, whereas it needed frequent repetition.

DR. O'BRIEN, in replying, said that a surgeon could not completely remove the disease. The light treatment would cure completely if it were given sufficeint time. As regarded the difference between X-rays and Finsen light, the ultra-violet rays were supposed to be bactericidal. With regard to applications. Finsen used a 9 per cent. pyrogallic acid ointment along with the

light, to give better transmission with beneficial results. His experience was that fifteen minutes' sitting gave scarcely any reaction, and he had prolonged sittings to an hour and ten minutes.

Paroxysmal Tachycardia.

DR. JOSEPH O'CARROLL recorded a case which came under his notice in the Whitworth Hospital, Dublin, in July, 1901. The patient was a governess, unmarried, aged thirty-four, who fourteen years previously began to suffer from attacks of violent substernal pain accompanied by rapid cardiac action. These attacks, occasional at first, gradually grew more frequent, till in 1900 they had increased to about five per week. In duration they varied from a few minutes to a few hours. Their onset was preceded by dimness of vision, sometimes amounting to almost complete blindness. Tachycardia was a constant accompaniment of the pain, the heart's rate on some occasions reaching 260 beats per minute. An attack would end by a brief but violent exacerbation of pain and a subjective sensation of something shifting from left to right in the thorax. Many lines of treatment were tried in vain, till finally Dr. O'Carroll administered bromide in gradually increasing doses, when, *post hoc* or *propter hoc*, the paroxysms of pain and heart hurry improved so much that it is now six months since the last attack. The author suggested the possibility of this case being one of "visceral epilepsy."

The Section then adjourned.

THE SOCIETY OF MEDICAL PHONOGRAPHERS.

THIS Society will hold its next Annual Shorthand Examination early in May, 1903. Two prizes will be offered, each of the value of £3, one for first-year students and one for students of more than one year's standing. The competition will be open to any Registered Medical Student in the United Kingdom who has not taken a first prize at one of the Society's previous examinations. It will be held simultaneously in London, Edinburgh, Dublin, and at any provincial medical centre in the United Kingdom at which a candidate or candidates shall offer themselves. There is no entrance fee for the examination. Intending candidates should send in their names as early as possible to Dr. P. G. Griffith, Bonhams, Farnborough, Hants., who will furnish them in return with a detailed Prospectus of the Examination. The latest date for receiving entries will be April 15th, 1903.